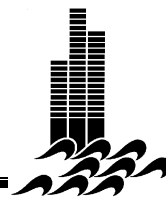


Return to: City of Long Beach  
Dept. of Human Resources & Affirmative Action  
333 W. Ocean Blvd., 13<sup>th</sup> Floor  
Long Beach, CA 90802



## Statement of Claim

## In-Hospital Indemnity

<b>PART A</b>  Employee's Statement   <b>Attach Copy of hospital bill</b>	1. Employee's Name _____ Age _____
	2. Address _____ Street and Number City State Zip
	3. Social Security Number _____
	4. If claim is for an eligible Dependent complete this section. Name of Dependent: _____ Birthdate ____ / ____ / ____ Relationship: _____ Social Security Number _____ If Student age 19 to 25: a. Name of school: _____ b. Course of study: _____ Number of current units _____
	5. Do you or does your dependent intend to present a claim for Workmen's Compensation arising out of this disability? _____
	6. I certify that the above answers are true and complete to the best of my knowledge and belief. Signed _____ Signed _____ Insured Employee Dependent if patient and not a minor Date ____ / ____ / ____

<b>PART B</b>  Physician's Statement	1. Name of Patient _____ Age _____
	2. Diagnosis of Record _____
	3. Has Patient ever had same or similar condition? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, date of previous treatment _____
	4. Is Disability due to patient's occupation? _____
	5. Date of hospital admission _____ Date discharged _____
	6. Name of Physician _____ Please Print Signature _____ Date ____ / ____ / ____